2008
Version

INSTRUCTION MANUAL

PERSON-CENTERED PLANNING

"Building Partnerships & Supporting Choices"

NC Division of MH/DD/SAS
(919) 715-2780
www.ncdhhs.gov/mhddsas/

Person-Centered Planning Instruction Manual (2008 Version)

**Posted on Division Web-site to accompany revised PCP forms.*

For additional information on Person-Centered Planning, please visit the following web link:

http://www.ncdhhs.gov/mhddsas/pcp.htm

Continue to visit the Division's Website at http://www.ncdhhs.gov/mhddsas/ for updated information regarding "Person-Centered Planning.

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"Person-Centered Planning is an outward sign of the presence of respect for the value of all persons."

I. PURPOSE OF PERSON-CENTERED PLANNING WITHIN THE NC DIVISION OF MH/DD/SAS

Since the inception of the Person-Centered Plan (PCP) in 2006, the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services has supported and encouraged the utilization of person-centered planning and the professional development and growth of all people engaged in the process. Through ongoing evaluation of the PCP, the Division of MH/DD/SAS has monitored the achievement of objectives using quantifiable measures, assessed the effectiveness of particular interventions and policies, as well as monitored public opinion. Subsequently, the PCP has been revised, taking into careful consideration legislative requirements, new priorities that have emerged, innovative approaches that are available, and/or evaluative information that has provided new direction for the plan.

The purpose of the ***2008 PCP Instruction Manual*** is to assist and enhance Plan Developers in their knowledge and skills related to person centered planning (PCP). Additionally, it is to be used as a tool to help guide the completion of the forms required for a PCP. While there are many elements to consider in person-centered planning, perhaps the most important thing to remember is that it is an ongoing, interactive, team process.

II. OVERVIEW

The State Plan: A Blueprint for Change establishes person-centered planning as fundamental to transformation within the mental health, developmental disability, and substance abuse service system. Person-centered planning is a process of determining real-life outcomes with individuals and their families, as well as developing strategies to achieve those outcomes. The process supports strengths and recovery and applies to **everyone** supported and served in the system. Person-centered planning provides for the individual with or the family of a child with a disability assuming an informed and in-command role for life planning, service, support and treatment options. The person with a disability, and his/her family, or the legally responsible person directs the process and shares authority and responsibility with system professionals about decisions made. For children and families, a Child and Family Team (CFT) is the vehicle for person-centered planning.

A. Key Values and Principles

Person centered planning is based on a variety of approaches, values, principles or "tools" to organize and guide community change and life planning with people with disabilities, their families and friends. All approaches or "tools" have distinct practices, but share common beliefs. Although the NC Division of MH/DD/SAS does not require the use of a specific "tool", the key values and principles listed below must be evident in the planning process.

"All people have the right to plan lives for themselves that are personally meaningful and satisfying."

THE KEY VALUES AND PRINCIPLES SERVING AS THE FOUNDATION OF PERSON-CENTERED PLANNING

1. *Person-centered planning builds on the individual's /family's strengths, gifts, skills and contributions.*
2. *Person-centered planning supports personal empowerment, and provides meaningful options for individuals/families to express preferences and to make informed choices in order to identify and achieve their hopes, goals and aspirations.*
3. *Person-centered planning is a framework for providing services, treatment, supports and interventions that meet the individual's/family's needs, and that honors goals and aspirations for a lifestyle that promotes dignity, respect, interdependence, mastery and competence.*
4. *Person-centered planning supports a fair and equitable distribution of system resources.*
5. *Person-centered planning processes create community connections. They encourage the use of natural and community supports to assist in ending isolation, disconnection and disenfranchisement by engaging the individual/family in the community.*
6. *Person-centered planning sees individuals/families in the context of their culture, ethnicity, religion and gender. All of the elements that compose a person's individuality and a family's uniqueness are acknowledged and valued in the planning process.*
7. *Person-centered planning supports mutually respectful partnerships between individuals/families and providers/professionals, and recognizes the legitimate contributions of all parties involved.*

B. The Person-Centered Plan as a Unified Life Plan

The Person-Centered Plan (PCP) is the umbrella under which all planning for treatment, services and supports occurs. Person-centered planning begins with the identification of the reason the individual/family is requesting assistance. It focuses on the identification of the individual's/family's needs and desired life outcomes-not just a request for a specific service. The plan captures all goals

"All people have talents and strengths that they have the responsibility to develop."

and objectives and outlines each team member's responsibilities within the plan. This plan is based on preferences and strengths for individuals identified by people who know and care about the person, which then supports good action and crisis planning. Natural and community supports should always be considered within all person-centered plans.

Child and Family Team (CFT)

In the case of children and youth, the person-centered planning process is a function of a Child and Family Team (CFT). Child and Family Teams are family members and their community supports that come together to **create, implement** and **update** a plan **with** the child, youth/student and family. The plan builds on the strengths of the child, youth and family and addresses their needs, desires and dreams. Members of the Child and Family Team are selected by the family and include natural and community supports and any public and private child serving agencies that are or may need to be involved. If the child is in state custody, the system shares this decision with the family at whatever level is appropriate for the safety of the youth, family and community. Members include, but are not limited to: juvenile justice, child welfare, schools, public health, other mental health, or other substance abuse or developmental disability providers.

During a Child and Family Team meeting, the members identify family strengths, needs, goals/family-driven outcomes, and outline an action plan for all team members. Child and Family Teams are important because they bring together all the individuals important in the lives of children, youth, and their families to reduce fragmentation of services and provide a vehicle of support for all members of the team. They enable creativity, assure better use of scarce resources, and ensure complex tasks get done without overwhelming individual team members.

The Child and Family Team process is a key component of the wraparound planning process and is at the heart of NC's System of Care. System of Care is the national standard of best practice to plan and deliver services to children and families with complex needs.

Key Principles of System of Care in NC[3]

- ***Child and Family Team Based***
- ***Family Driven and Youth Guided***
- ***Natural Supports***
- ***Collaboration***
- ***Community Based***
- ***Culturally and Linguistically Competent***
- ***Individualized***
- ***Strengths Based***

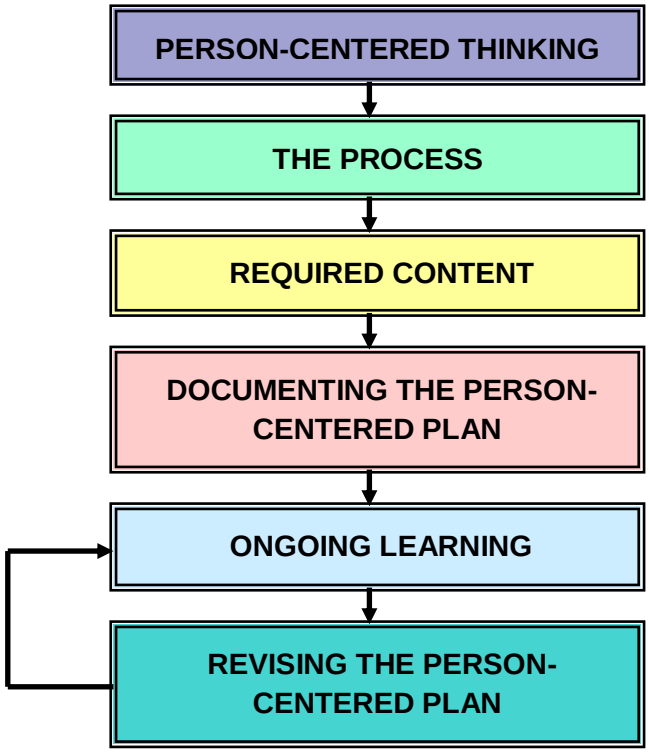
[1] Endorsed by the NC Collaborative for Children, Youth and Families, December 2007. For more information go to: www.nccollaborative.org.
[2] MeckCARES Training Institute, Module CFT 101, 2007.
[3] Adapted from Bruns, E.J., Walker, J.S. Adams, K., Miles, P., Osher T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Advisory Group (2004). Ten principles of the wraparound process. Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University and MeckCARES Training Institute, Module CFT 101, 2007.

"Person-Centered Planning is a way of thinking about people that respects their interests, hopes, dreams, and desires."

III. THE FRAMEWORK FOR DEVELOPING A PERSON-CENTERED DESCRIPTION/PLAN

Best Practice tells us that a good "Plan" is actually a "DESCRIPTION" of the individual/family. The description tells us what their life looks like now, what needs to remain the same, what needs to change, where they see themselves in the future and the support needed to get there. We continue to use the word "Plan" throughout the PCP format and manual for ease of recognition and understanding of the process.

You will learn about six phases that form a framework for person centered planning: Person-centered thinking, the process, required content, documenting the PCP, ongoing learning, and revising the PCP. Below we have provided a detailed description of four of the phases in an effort to guide you through the planning process.



A. PERSON-CENTERED THINKING

For people/families receiving mh/dd/sa supports and services, it is not person-centered planning that matters as much as the pervasive presence of person-centered thinking.

- If people/families who use services are to have self directed lives within their own communities, then those who play a primary role in facilitating service plans and providing services and supports need to have person-centered thinking skills.

"Person-Centered Planning is a guided process for organizing and communicating what is IMPORTANT TO and FOR an individual in "user friendly" plain language."

- Person-centered thinking is a set of value-based skills that change the way we see individuals/families, change the way we support individuals/families, set the stage for ongoing learning about individuals/families and acting upon that learning.

Learning and supporting the use of person-centered thinking skills result in:

- Plans being developed that are used and acted on, so that the lives of people who use services will improve.
- Several ways to get plans started/revised/updated.
- Plans that occur 'naturally', needing less effort and time.

B. THE PROCESS

Person-Centered Planning is a process. This process enables people important to the person, as well as people that will provide supports and services to come together and state who, what, when, and where services will be offered. It is recognized that each plan will reflect the degree of information available/known at any given time. Therefore, information will continue to be gathered and added as more learning takes place.

The Person-Centered Planning process will utilize:

Information Gathering:

- The planning process may include one or more dialogues with the person to whom the plan belongs, and any others identified by this individual.
- The dialogues are initiated by the person responsible for writing the PCP (the QP). Dialogues may be formal or informal meetings, telephone conversations, any discussion used to gather needed information.
- The QP from any service that meets the designation of clinical home will be responsible for gathering information and developing the PCP. In some services the QP may be a licensed professional (LP), while others are those that meet the QP requirements in core rules.
- Discussions within the dialogues/meetings should include information about aspirations and goals.
- Decisions are made by the individual/family/legally responsible parties and professionals working together to determine services, supports and treatment, including natural and community resources, that can best meet the person's identified desires and needs.

"A person with a disability who is protected from failure is also protected from potential success."

Unified Planning

Since the person-centered plan is the umbrella under which all planning for support and treatment occurs, all facets of support/treatment representing the individual's aspirations and goals must be documented within it. All resources, including natural and community, are to be included in the plan.

- When agreed upon by the person and other planning participants, goals and supports/interventions may be developed by a provider for a specific service; however **separate plans may not be developed by individual providers.** Specialized sets of goals must be integrated into the unified PCP by the QP/LP.
- When specialized service-specific goals are not included initially, they may be added when needed, as an update/revision to the plan.
- Any specialized service-specific goals that are added to the PCP must relate to and be drawn from the Important TO and Important FOR information in the dialogue pages, as are all other goals.
- Non-clinical home, specialized providers may participate in the planning process by:
  - ❖ Attending a full treatment team meeting meant to develop goals.
  - ❖ Receiving copies of the information gathered during dialogues to use to develop goals and then submit them to the PCP writer.
  - ❖ Contacting the PCP writer by phone to discuss specialized service goals needed.
  - ❖ Any other way as described above in Information Gathering.
  - ❖ **Remember: Nothing should be added to a PCP without agreement from the individual/family/legally responsible person.**
  - ❖ The person responsible for the PCP (the QP/LP), must ensure that the person to whom the plan belongs and all other providers documented in the plan receive a copy of the plan that includes all the appropriate signatures and consequent Update/Revisions.

Authorization

- After the PCP is completed, the QP/LP submits the plan to the identified service authorization agency for review.
- The service authorization agency reviews the PCP to ensure that medical necessity has been met for the requested treatment/services.
- *Please refer below to **Section C: Required Content** for specific information on first authorizations and ongoing authorizations.*

"Person-Centered Planning supports mutually respectful and partnering relationships, acknowledging the legitimate contributions of all parties."

C. **REQUIRED CONTENT**

An <u>Introductory PCP</u> is an initial plan which may only be used for an individual who is new to the MH/DD/SA system, or an individual who has been completely discharged from services and has not received any MH/DD/SA services for 60 days or longer. Use of an Introductory PCP allows the provider to quickly gather the information needed to request authorization from the service authorization agency.

- A person new to the mh/dd/sa system, per the description above, may be referred to an appropriate service through a Screening/Triage/Referral (STR) process, or may directly contact any provider agency of their choosing for appropriate services.

- Prior to service delivery, a Comprehensive Clinical Assessment must be completed. This assessment is not submitted to the service authorization agency.

- When an Introductory PCP is used, it must be completed by a QP/LP from the chosen provider organization for any of the following services:

  - Assertive Community Treatment Team **(ACTT)**
  - Community Support – Adult **(CS-Adult)**
  - Community Support – Child/Adolescent -**(CS-Child/Adolescent)**
  - Community Support Team **(CST)**
  - Intensive In-Home **(IIH)**
  - Multisystemic Therapy **(MST)**
  - Substance Abuse Comprehensive Outpatient Treatment **(SACOT)**
  - Substance Abuse Intensive Outpatient Program **(SAIOP)**
  - Targeted Case Management **(TCM)**

- Pre-authorization, or prior approval is required for Medicaid services, with the exception of Mobile Crisis Management, Facility Based Crisis, and Inpatient. Requests for pre-authorization must be submitted to the service authorization agency prior to service delivery.

- **Targeted Case Management is the only service that offers 8 unmanaged hours prior to service authorization.** The QP may bill up to 8 hours of TCM services while gathering information and completing the Introductory PCP for submission to the service authorization agency for service authorization. This allows a short window of time for the TCM QP to work with the consumer and his/her family to determine what service(s) may be appropriate for the individual. The 8 hours of pass through TCM services is a once in the lifetime event. **All other services require prior authorization. (Refer to Implementation Update # 46)**

"The insight of family and friends can complement and enhance the expertise of professionals on the team."

The following elements constitute the documents required to process an <u>Introductory PCP</u> and <u>initial authorization</u>:

(Introductory PCP & Initial Authorization pages required):

- **Action Plan** page(s) from the PCP.
- **Summary of Assessment/Observations** page with only the Diagnosis, Current Medications, and Listing of all Known Allergies needing to be complete.
- **Crisis Prevention/Crisis Response (Continuation)** page of the PCP (the 2nd page of the Crisis Plan reflecting contact and other information).
- **Signature Pages** from the PCP including:
  - ✓ Service Order/Confirmation of Medical Necessity-Dated signature is required, plus each of the following must be addressed by the licensed professional who signs the service order.
    - ☐ Confirmation of medical necessity
    - ☐ Confirmation of the review of the comprehensive clinical assessment, and
    - ☐ Verification that the LP signing the service order has had direct contact with the consumer.
  - ✓ Person Receiving Services - Dated signature is required when the person is his/her own legally responsible person.
  - ✓ Legally Responsible Person - Dated signature when the person receiving services is not his/her own LRP.
  - ✓ Person Responsible for the Plan - Dated signature is required. Completion of each of the required boxes on the signature pages of the PCP by the Person Responsible for the Plan is also required for individuals under the age of 21 (Medicaid) or under age 18 (State) who are:
    - ☐ Receiving enhanced services and;
    - ☐ Actively involved with the Department of Juvenile Justice and Delinquency Prevention or the Criminal Court System.
- **(NOTE):** Check boxes left blank on the signature pages of the PCP will be returned as incomplete by the service authorization agency.
- **Inpatient Treatment Report** (ITR) form, or **ORF2**, or **CTCM**.
- **LME Consumer Admission and Discharge Form** (required for submission to the LME)
- Prior to service delivery, a **Comprehensive Clinical Assessment** must be completed. This assessment is **not** submitted to the service authorization agency.

"Helping an individual discover their lifestyle and carefully supporting that choice can be transformational."

AUTHORIZATION & FOLLOW-UP PROCESS

- **When any service is pre-authorized by the service authorization agency:**

  - The authorization is in effect for the duration indicated by the service authorization agency.
  - Prior to the end of the first authorization period, the following must be completed and submitted to the service authorization agency for any further authorization to occur:
    - ✓ New ITR/ORF-2/CTCM Form
    - ✓ Complete PCP
  - Prior to service delivery, a Comprehensive Clinical Assessment must be completed. This assessment is not submitted to the service authorization agency.

  - **The Comprehensive Clinical Assessment (CCA) may include but is not limited to:**
    1) T1023-Diagnostic Assessment
    2) 90801-Clinical Evaluation/Intake
    3) 90802-Interactive Evaluation
    4) 96101-Psychological Testing
    5) 96110-Developmental Testing (Limited)
    6) 96111-Developmental Testing (Extended)
    7) 96116-Neuropsychological Exam
    8) 96118-Neuropsychological Testing Battery
    9) H-0001-Alcohol &/or Drug Assessment
    10) H-0031-Mental Health Assessment
    11) Evaluation & Management (E/M) Codes
    12) YP830-Alcohol &/or Drug Assessment-non-licensed provider (State $ only)

NOTE: Refer to PCP Instruction Manual – (Appendix A) for Division of MH/DD/SAS Implementation Bulletin # 36 for guidelines on the elements of a Comprehensive Clinical Assessment for each disability area.

- **No additional authorizations will be granted based on an Introductory PCP.**

- **All of the pages of the PCP described in the remainder of this document constitute the Complete PCP.**

"Standardized outcomes in lifestyle planning will always fail at the level of the individual, because no two people are the same."

The following elements constitute the documents required to process a <u>Complete PCP</u>:

(Remember: All Person-Centered Plans must be re-written annually based on the Date of Plan.)

Required Content for a <u>Complete PCP</u> will include the following PCP pages:

- Identifying Information
- Participants Involved in Complete Plan Development
- Personal Dialogue/Interview
- Family, Legally Responsible Person, Informal Supports Dialogue/Interview
- Service/Provider Dialogue/Interview
- Summary of Assessments and Observations
- Action Plan
- Crisis Prevention/Crisis Response
- Crisis Prevention/Crisis Response (Continuation)
- Signature Page
- Update/Revision page and Update/Revision Signature page

D. DOCUMENTING THE PERSON-CENTERED PLAN

***IMPORTANT* (Please read before proceeding to the next sections of the instruction manual)**

One of the essential concepts within person-centered thinking is that of understanding the balance between what is "**<u>Important TO</u>**" and "**<u>Important FOR</u>**" the person/family to whom the plan belongs. This skill is critically important not only in the following dialogue/interview processes, but throughout the complete planning process.

"Please integrate the skill of finding the balance between "Important TO" and "Important FOR" throughout the planning process."

Many different person-centered tools have been developed that can be used in the transition process-

Online resources with more information on person-centered planning tools and training can be found at:

http://www.learningcommunity.us/home.html

- What is **"important to"** a person/family includes only what that person is "saying" with their words and with their behaviors. (Example: Many people/families have lived in circumstances where they were expected to say what others wanted them to say. If a person is saying what they think we want to hear, it is important to 'listen' to their behavior to help decide what is really being said, the underlying message of truth. We may need to use a symbolic "third ear" to hear fully and accurately.)

- What is **"important for"** people/families includes those things that need to be kept in mind for people/families regarding: Issues of health or safety and what others see as important for the person to be a valued member of their community (in relationships, school, work, etc.) [1]

  (**EXAMPLE**: A young adult with a cognitive disability may see "adventure", "new experiences", "cars", and "sports" as important **TO** him or her, while the parents may see "safety", "protection", and "security" as important **FOR** the young adult)

Why do this?

Finding the balance between **"important to"** and **"important for"** is the fundamental person-centered thinking skill. People/families in the public service system may be in circumstances where others exercise control over them. What is **"important for"** them is addressed, while what is **"important to"** them is ignored or seen as what is done when time permits. [2]

- **Informal Services/Supports –** Every effort should be made to use these resources before resorting to the utilization of paid supports.
  a. **Personal Resources:** The person's own resources, such as special skills, capacities, or attributes, should be examined and included in the plan.
  b. **Natural Supports:** Natural supports include family, neighbors, co-workers, and friends of the individual/family's choosing. Existing supports should be included if applicable and new ones explored.
  c. **Community Resources:** Community resources are those that exist for any community member's use. Examples include church or faith-based organizations, Boy's or Girl's Clubs, YMCA or YWCA, special interest or civic groups, sports or any other group available to other community members. Opportunities to connect the individual/family to the community must be explored and offered.

- **Formal Services/Supports** – This is paid assistance provided by qualified professionals or paraprofessionals in the publicly funded system of services.

[1] *Ibid, Chapter 1, page 20*
[2] *Essential Lifestyle Planning for Everyone by Michael W. Smull and Helen Sanderson, 2005, Chapter 1, page 2*

IV. PERSON-CENTERED DESCRIPTION/PLAN INSTRUCTIONS

A. Identifying Information (Page 1 of PCP)

- Enter the name that the person prefers to be called in the section titled:

  _____'S PERSON-CENTERED DESCRIPTION/PLAN

Name: *(Person's legal name)* **Preferred Name:** *(Enter the name that the person prefers to be called)*	**DOB:** (*mm/dd/yyyy)*	**Medicaid ID:** (*Enter identification noted on current Medicaid card)*	**Record #:** (*Enter the record number assigned by the LME)*
Person's Address: **(Street/mailing address)** **(City/State/Zip)**			**Telephone #:** (*Enter the telephone number(s) of the person receiving services)*
Date of Plan: (*mm/dd/yyyy)* **Date of 1st Complete PCP if prior plan was an Introductory PCP:** (*mm/dd/yyyy)* *NOTE: Date of plan is the date the QP/Licensed Professional (per the Service Definition) completes the PCP* ***AND*** *signs and dates the signature page.* ***(See "Dating the PCP" below.)***		**CAP-MR/DD Only:** (Check the box that applies) ☐ Supports Waiver ☐ Supports Waiver – Self Direction ☐ Comprehensive Waiver	

Dating the PCP

	INTRODUCTORY PCP	1st COMPLETE PCP	ALL OTHER COMPLETE PCPs	CAP-MR/DD PCPs
DATE OF PLAN	The *Date of Plan* is the date that the QP/LP (per the Service Definition) *completes and signs* the Introductory PCP.	The *Date of Plan* on the 1st Complete PCP is the same Date of Plan as on the Introductory PCP. The date of the 1st Complete PCP if prior plan was an Intro PCP is the date the QP/LP completes and signs the new plan.	The *Date of Plan* on the PCP is the date that the QP/LP (per the Service Definition) *completes and signs* the PCP.	The *Date of Plan* is the date that the PCP planning meeting occurred and **must occur** in the month prior to the birth month of the individual.
TIME PERIOD THAT PCP IS VALID	The Introductory PCP is valid for the first authorization period approved by the Service Authorization Agency.	The 1st Complete PCP following an Intro PCP is valid for 12 months from the Date of Plan, carried over from the Intro PCP.	12 months from the Date of Plan	12 months from the Effective Date of Plan

(Dating the PCP) – CONTINUED:

	INTRODUCTORY PCP	1ST COMPLETE PCP	ALL OTHER COMPLETE PCPS	CAP-MR/DD PCPS
TARGET DATES	Target dates should not exceed the period of the first authorization. If they do, the Intro PCP is still only valid through the first authorization period.	Target dates may not exceed 12 months from the Date of Plan: *Intro PCP + 1st Complete PCP = 12 months.*	Target dates may not exceed 12 months from the Date of Plan.	Target dates may not exceed 12 months from the Effective Date of Plan.
MEDICAL NECESSITY & SERVICE ORDERS	Must be in place for the Introductory PCP to be valid for billing.	• If no new services were added, the service order on the Intro PCP is valid through the life of the 1st Complete PCP – for 12 months. • If new services are added in the 1st PCP, a new service order is needed and is valid only for the remainder of the first 12 month period. • If new services are added during an Update/Revision to the PCP, a new service order must be obtained and is valid only for the remainder of the first 12 month period.	• Must be in place for the PCP to be valid for billing. • A new service order/ verification of medical necessity must be obtained with each annual rewrite of the PCP. • If new services are added during an Update/Revision to the PCP, a new service order must be obtained.	• Services must be ordered by the Targeted Case Management QP. • A new service order/verification of medical necessity must be obtained with each annual CNR. • If new services are added during an Update/Revision to the PCP, a new service order must be obtained.
SIGNATURE/ PCP EFFECTIVE DATES	• No signatures, including the licensed professional, the legally responsible person and the QP/LP responsible for the PCP may precede the Date of Plan. • If any of the 3 required signatures above were entered after the Date of Plan, the latest date is the date on which the PCP is effective and the date billing for services may begin. However, the Date of Plan is still in effect for target dates and the annual rewrite date.	• The Intro PCP is valid through the end-date of the first service authorization. In order to have continuous billing from the Intro PCP through the 1st Complete PCP, signatures for the Complete PCP must be obtained and dated no later than the day after the 1st authorization expires. • No signatures, including the licensed professional, the legally responsible person and the QP/LP responsible for the PCP may precede the 1st Complete PCP date. • If any of the 2 or 3 (if there is a new service order) required signatures above were entered after the 1st Complete PCP, the latest date is the date on which the PCP is effective and the date billing for services may begin. However, the Date of Plan is still in effect for target dates and the annual rewrite date.	• No signatures, including the licensed professional, the legally responsible person and the QP/LP responsible for the PCP may precede the Date of Plan. • If any of the 3 required signatures above were entered after the Date of Plan, the latest date is the date on which the PCP is effective and the date billing for services may begin. However, the Date of Plan is still in effect for target dates and the annual rewrite date.	• Signatures of QP/LP ordering services, the legally responsible person and the QP/LP responsible for the PCP must be obtained prior to the effective date of the plan. • The effective date of the plan is the first day of the month following the birthday month, contingent upon PCP approval.
ANNUAL REWRITE / CONTINUED NEED REVIEW (CNR)	N/A	• **The *Date of Plan* on the first Complete PCP is the date on which the annual re-write of the PCP is based.** • A new service order/ verification of medical necessity must be obtained with each annual rewrite of the PCP.	• **The *Date of Plan* on the Complete PCP is the date on which the annual re-write of the PCP is based.** • Medical necessity must be verified and services ordered with each annual rewrite of the PCP, even if the last verification/service order is less than 12 months old.	• The CNR takes place during the month before the birthday month. • Medical necessity must be verified and services ordered with each CNR.

B. Participants Involved in Complete Plan Development – (Page 1 of PCP)

Name: *(Enter the name of the individuals participating and providing any form of input into the development of the plan) -* ***The 1st box is reserved for the individual's participation.***

Relation/Agency: *(Enter the relationship and agency, if applicable, of each participant)*

How long have you known each other? *(Enter the length of time that you have known the individual)*

Role: *(Check the box or boxes that define each participant's involvement in Plan development)*

- ☐ Facilitator of PCP/CFT meetings
- ☐ Participated in @ least 1 planning meeting
- ☐ Provided written input
- ☐ Telephone participation
- ☐ Invited, but no participation
- ☐ Other:

Other: (*List the individuals that the person/family would like to be a part of the planning process now or in the future.)*

- Include the individual's name as a participant in the development of the plan.
- For all individuals receiving services, it is important to include people who are important in the person's life such as family, legally responsible person, professionals, friends and others identified by the individual/family (i.e. employers, teachers, faith leaders, etc.) in the planning process. These individuals can be essential to the planning process and help drive its success. The individual and/or the legally responsible person identify who will participate in the planning process, how and to what extent.

C. HEADER – (Page 2 of PCP)

Name: *(Person's legal name)*	**DOB:** (*mm/dd/yyyy)*	**Medicaid ID:** (*Enter identification noted on current Medicaid card)*	**Record #:** (*Enter the record number assigned by the LME)*

- Text entered in the header will appear on the remaining pages of the PCP.
- To insert the text, click on (**View**) on your (**Windows-Word toolbar**), then click (**Header/Footer**), and then insert your text.

D. Personal Dialogue/Interview – (Page 2 of PCP)

<u>This section must include what is IMPORTANT TO the person to whom this plan belongs.</u>

- Personal dialogue/interview is used to gather information and is an assessment of the different life areas, skill levels, family, education, work history, etc. This is how the relationship is developed and it starts with the information staff gathers and continues to add on as the relationship builds. Every contact is an opportunity to learn something new about the person and this information needs to be reflected.
- Provide as necessary, language and/or deaf/hard of hearing interpreters for the individual/family as required per Administrative Rule 10A NCAC 27D .0303, Informed Consent.
- Include issues related to the person's environment, culture, ethnicity and race as appropriate.
- The individual to whom this plan belongs may complete this section of the plan if so desired. If not, staff will document as closely as possible, the exact words shared.
  - ❖ Using the 3rd person in this section is preferable to possibly misquoting the person in the 1st person.
  - ❖ It takes a lot of skill to master the use of 1st person for this exercise. The plan writer should use 1st person as he/she becomes comfortable with it.
- In order to protect a person's health, safety, welfare, and the person's freedom, it is necessary to identify health and safety factors and to create supports and back up plans aimed at minimizing risk and promoting wellness. Risks should be addressed by helping a person look at ways to be safe within the choices made. This **Important FOR** information should be addressed in the Family and Provider dialogue pages, *unless* the individual has made it clear that they consider the information to be important to him/her.
- **<u>Note</u>: Add/revise whenever there is new information about this person. Sign your name (no initials) and date next to the new information, each time you add/revise. Additions/changes to any of the Dialogue pages do not constitute a formal review. The Update/Revision Signature page is <u>NOT NEEDED</u> unless these changes result in additions or changes to services or goals.**

Personal Dialogue/Interview – (Page 2 of PCP): Continued

What is working best in my life right now? (What makes the most sense for me right now? What needs to stay the same?)	**What is not working in my life now?** (What does not make sense for me right now? What needs to change?)

Strengths: (What are my special talents/traits? What do I **like** and **admire** about myself?)

What is Important TO me: (What are the people/activities/things/places that matter to me in everyday life? What do I not want in my life?)

(Critical elements):

- *Issues that are **Important TO** the individual/family must be recorded even if other people spoken with offer information that may conflict.*
- *This plan belongs to the individual who will receive the services. This is his/her personal section and must be reserved to record only that information determined to be important by this person.*
- *Often it is the people who know the individual the best (family, friends, and providers) who identify what is **Important FOR** the individual. That information should not be recorded here, but documented in the Family/Legally Responsible Person/Informal Supports and/or Service/Support Provider dialogue/interview sections.*
- *For very young children, or individuals who don't use words to communicate, there may be family or others who know the person well enough that they can talk about what is **Important TO** that person (NOT what they think is **Important FOR** them). That information may be documented here, indicating who provided it.*

Supports: (What do others need to know or do to support me best in relationships, in things I like to do, in work or school and ways to stay healthy and safe, taking in to account what is Important **TO** me?)

- ***Health and safety -** In order to protect a person's health, safety and, consequently the person's freedom, it is necessary to identify health and safety risk factors and to create supports and back up plans aimed at minimizing risk. Risk should be addressed by helping a person look at ways to be safe within the choices made.*
- ***Health and Wellness –** Overall healthcare and wellness issues should be addressed here.*
- *Include information here that is needed to complete the crisis plan.*

Long Term Outcomes: (What are the things I want to accomplish in the next year? What are my hopes/dreams for the future?)

E. Family, Legally Responsible Person, Informal Supports Dialogue/Interview – (Page 3 of PCP)

- Include issues related to the person's environment, culture, ethnicity and race as appropriate.
- Information should be gathered through a series of conversations with people important to the individuals and their families. The guiding questions on the form are not all inclusive.
- The legally responsible person may fill this out. Documentation on this page should reflect information given by the family member/s, guardian and informal supports providers participating in plan development.
- Critical elements to identify are what is important **TO** the person/family and what is important **FOR** the person/family.
- Personal dialogue/interview is used to gather information and is an assessment of the different life areas, skill levels, family, education, work history, etc. This is how the relationship is developed and it starts with the information staff gathers and continues to add on as the relationship builds. Every contact is an opportunity to learn something new about the person and this information needs to be reflected.

NOTE: Add/revise whenever there is new information about this person. Sign your name (no initials) and date next to the new information, each time you add/revise. Additions/changes to any of the Dialogue pages do not constitute a formal review. The Update/Revision Signature page is NOT NEEDED unless these changes result in additions or changes to services or goals.

NOTE: Often it is the people who know the individual the best (family, friends, providers) who can most clearly identify what is important FOR the individual. These issues can be related to health and safety concerns including for example, medical, psychiatric, social, and/or behavioral issues. If the person does not want family members involved and the person is his/her own legally responsible party, indicate that on this page and do not complete further.

What is working best in his/her life right now? (What makes the most sense for him/her right now? What needs to stay the same?)	**What is not working in his/her life now?** (What does not make sense for him/her right now? What needs to change?)

Strengths: (What are the person's special talents/traits? What do people **admire** about this person?)

Family, Legally Responsible Person, Informal Supports Dialogue/Interview – (Page 3 of PCP): Continued

What is Important FOR this person: (What are the people/activities/things/places that matter to this person in everyday life? What does this person not want in his/her life?)

Supports: What is important **FOR** this person? (What do others need to know or do to support this person best in relationships, in things that they like to do, in work or school and ways to stay healthy and safe?)

- ***Health and safety -*** *In order to protect a person's health, safety and, consequently the person's freedom, it is necessary to identify health and safety risk factors and to create supports and back up plans aimed at minimizing risk. Risk should be addressed by helping a person look at ways to be safe within the choices made.*
- ***Health and Wellness –*** *Overall healthcare and wellness issues should be addressed here.*
- *Include information here that is needed to complete the crisis plan.*

Long Term Outcomes: (What are the things he/she wants to accomplish in the next year? What are his/her hopes/dreams for the future?)

F. Service/Support Providers Dialogue/Interview – (Page 4 of PCP)

- Include issues related to the person's environment, culture, ethnicity and race as appropriate.
- Information should be provided as outlined in the prompts for each section. The prompts should not be considered all inclusive.
- The person responsible for the plan/clinical home should fill this out after talking with applicable providers. Documentation should reflect information given by the services and supports providers participating in plan development.

NOTE: Add/revise whenever there is new information about this person. Sign your name (no initials) and date next to the new information, each time you add/revise. Additions/changes to any of the Dialogue pages do not constitute a formal review. The Update/Revision Signature page is NOT NEEDED unless these changes result in additions or changes to services or goals.

NOTE: Often it is the people who know the individual the best (family, friends, providers) who can most clearly identify what is important FOR the individual. These issues can be related to health and safety concerns including for example, medical, psychiatric, social, and/or behavioral issues. If the person does not want family members involved and the person is his/her own legally responsible party, indicate that on this page and do not complete further.

Service/Supports Provider Dialogue/Interview – (Page 4 of PCP): Continued

What is working best in his/her life right now? (What makes the most sense for him/her right now? What needs to stay the same?)	**What is not working in his/her life now?** (What does not make sense for him/her right now? What needs to change?)

Strengths: (What are the person's special talents/traits? What do people **admire** about this person?)

What is Important FOR this person: (What are the people/activities/things/places that matter to this person in everyday life? What does this person not want in his/her life?)

Supports: What is important **FOR** this person? (What do others need to know or do to support this person best in relationships, in things that they like to do, in work or school and ways to stay healthy and safe?)

- ***Health and safety -*** *In order to protect a person's health, safety and, consequently the person's freedom, it is necessary to identify health and safety risk factors and to create supports and back up plans aimed at minimizing risk. Risk should be addressed by helping a person look at ways to be safe within the choices made.*
- ***Health and Wellness –*** *Overall healthcare and wellness issues should be addressed here.*
- *Include information here that is needed to complete the crisis plan.*

Long Term Outcomes: (What are the things he/she wants to accomplish in the next year? What are his/her hopes/dreams for the future?)

G. Summary of Assessments and Observations – (Page 5 of PCP)

- A **Comprehensive Clinical Assessment** is a required element of the Completed PCP.
- The **Comprehensive Clinical Assessment may include**, but is not limited to:
  - T1023-Diagnostic Assessment
  - 90801-Clinical Evaluation/Intake
  - 90802-Interactive Evaluation
  - 96101-Psychological Testing
  - 96110-Developmental Testing (Limited)
  - 96111-Developmental Testing (Extended)
  - 96116-Neuropsychological Exam
  - 96118-Neuropsychological Testing Battery
  - H-0001-Alcohol &/or Drug Assessment
  - H-0031-Mental Health Assessment
  - Evaluation & Management (E/M) Codes
  - YP830-Alcohol &/or Drug Assessment-non-licensed provider (State $ only)

Summary of Assessments/Observations – (Page 5 of PCP): Continued

COMPREHENSIVE CLINICAL ASSESSMENT (CCA) (List the Comprehensive Clinical Assessments & evaluations that have been completed for the individual)	**RECOMMENDATIONS FROM ALL ASSESSMENTS** (Enter recommendations made as a result of all completed assessments)	**LAST DATE COMPLETED** (Enter the most recent completion date for each assessment)	**APPROXIMATE DUE DATE** (If re-assessment is recommended, enter the projected due date for the re-assessment. If re-assessment is not recommended, enter "N/A")
		/ /	/ /
		/ /	/ /
NC TOPPS (MH/SA only) ***(**Not a Comprehensive Clinical Assessment)		/ /	/ /
NC SNAP (DD only) ***(**Not a Comprehensive Clinical Assessment)		/ /	/ /
RISK ASSESSMENT TOOL (CAP-MR/DD only) ***(**Not a Comprehensive Clinical Assessment)		/ /	/ /

You can insert additional rows as needed in the table above.

- Place your cursor on the table where you would like to insert the row.
- Right click your mouse.
- Click Insert.
- Click Insert row above or below.

ADDITIONAL ASSESSMENTS RECOMMENDED *(If the above assessments indicated that other assessments would be beneficial, list them here)*	**REASON FOR RECOMMENDATION** *(Enter recommendations made as a result of all completed assessments)*	**APPROXIMATE DUE DATE** *(Enter the projected completion date for the assessment)*	**DATE COMPLETED** *(Enter the date of the completed assessment)*
		/ /	/ /

Summary of Assessments/Observations – (Page 5 of PCP): Continued

CHARACTERISTICS/OBSERVATIONS OF THIS PERSON: (Based on the interviews, dialogues, and assessments.)

(Enter characteristics and observations that will result in action plans)

- ***Characteristics/Observations*** *are those characteristics, qualities, actions that are representative of this person and the diagnosis of the person.*
- ***Examples of characteristics/observations are****, "is withdrawn", "hears voices", "has great difficulty in social situations", "destroys property", "is very angry", "unable to stay still", "talks about wanting to get high", etc.*

1.	4.
2.	5.
3.	6.

	(DSM* Code)	(Diagnosis)	(Diagnosis Date)
Axis I			/ /
Axis II			/ /
Axis III			/ /
Axis IV			/ /
Axis V			/ /

- **Mental Health/Substance Abuse** - All five axes must be addressed.
- **Developmental Disabilities** – Completion of Axis V is recommended.

(*The Diagnostic & Statistical Manual of Mental Health Disorders IV-TR, 2000 organizes psychiatric diagnosis on 5 axes. They are listed below):

Axis I: Major Mental Disorders: Developmental Disorders and Learning Disabilities
Axis II: Personality Conditions and Mental Retardation
Axis III: Any Non-Psychiatric Medical Condition
Axis IV: Social Functioning and how symptoms affect the person
Axis V: Global Assessment of Functioning (GAF) based on a scale of 100-0 for adults and/or the Children's Global Assessment Scale, also a 100-point scale

All Current Medications *(List the name of every current medication prescribed for the person. This includes psychiatric medications and all the other medications the person is taking. Update and revise list of medications whenever there is a change so that in the event of a crisis the information is correct. An update to the medication list alone will not constitute a revision to the plan.)*	**Dose:** *(Enter the dosage of each medication)* ***Example:*** *The amount of medicine administered and/or taken.*	**Frequency:** *(Enter the dosage frequency information as noted on the prescription)-* ***Example:*** *How often the medicine is administered and/or taken.*	**Reason for Change:** *(Enter the reason for the update/revision)* ***Example:*** *New medication, terminated medication, new dose, new frequency, etc)*	**Date** *(Enter the date of each initial prescription and each change.)*	**Pharmacy:** *(Enter pharmacy phone #, and Health Care provider phone #)*
1.				/ /	

List all Known Allergies: ***(*Update and revise list of allergies anytime there is a change). If none, enter "none".***	
1.	3.
2.	4.

H. Action Plan – (Page 6 of PCP)

- Potential service, support, intervention and/or treatment options to meet the goals and needs of the individual/family are identified and discussed in collaboration with professionals and other service providers in the publicly funded system of services.
- The individual/family/legally responsible person must be fully informed of the rationale, evidence and risks of specific service, support/intervention and treatment options in order to make responsible choices based on the options presented.
- Care should be taken to assure that purchased or funded supports do not take the place of natural supports and community resources when they are available and appropriate to the need.
- **Health and safety –** In order to protect a person's health, safety and consequently the person's freedom, it is necessary to identify his/her health and safety risk factors. These factors should be recorded in the dialogue/interview sections of the plan. Ensure that supports and back up plans aimed at minimizing risk are addressed in the Action Plan, based on the information gathered. Risk should be addressed by helping a person look at ways to be safe within the choices made.
- **Add additional copies of the Action Plan page as needed to address Long Range Outcomes, Characteristics/Observations, Short Range Goals, etc.**

Action Plan – (Page 6 of PCP): Continued

Long Range Outcome: *(Ensure that this is an outcome desired by the individual, and not a goal belonging to others.)*

(Based on the information gathered in the dialogues/interviews, in measurable terms, state the outcome the person/family desires to achieve within a year and/or into his/her future.

Where am I in the process of achieving this outcome?

(Based on the information gathered in the dialogues/interviews, briefly describe the person's current status, skills and abilities related to the identified long range outcome and the person's current level of participation related to this outcome)

CHARACTERISTIC/OBSERVATION #: *(For **Complete PCP**, list the characteristics/observation from the Summary of Assessments/Observations page here that supports the need for the short range goal below. Use clinical judgment to recognize the relationships between the characteristics/observations and the short term goals. More than one goal may be developed for a single characteristics/observation if necessary to fully address that need. Not needed for an **Introductory PCP.**)*

Short Range Goal (Taken from Preferences & Supports Sections ("What's important TO & FOR me")	Support/Intervention to Reach Goal (Taken from Supports Sections for Complete PCP)	Who will Provide Support/Intervention/ Service?	Support/Service & Frequency
*(Enter a person-centered measurable objective needed to achieve the long range outcome based on the **What's Important TO** and Supports sections of the dialogues/ interviews.*	*(Define the supports, interventions, services required to achieve the short range goal based on the Supports sections of the dialogues/interviews.*	*(Identify the individual(s) who will be responsible for implementing and documenting the progress toward the goal. **When the responsible person is a paid provider, indicate in this box the agency name and position of the person.** When possible, include the name of that individual as well)*	*(Identify the specific service/treatment to be used to address the goal and enter the frequency of that service.*

Target Date (Not to exceed 12 months.)	Reviewed Date	Status Code	Justification for Continuation/Discontinuation of Goal
Enter the date the team projects the person can achieve this goal. A target date may never exceed 12 months from the Date of Plan.	*Enter the date progress towards the goal was reviewed*.	*Based on the progress review, enter the status code.*	*If a goal is not achieved at the time of review, provide information justifying the reason the team determines to either continue or discontinue the goal.*
/ /	/ /	*(Enter the Status Code)*	*(Enter the Justification of Continuation/Discontinuation of Goal)*
Status Codes:	R=Revised	O=Ongoing	A=Achieved D=Discontinued

I. Crisis Prevention/Crisis Response – (Page 7 of PCP)

A crisis plan includes supports/interventions aimed at preventing a crisis (proactive) and supports/interventions to employ if there is a crisis (reactive).

- A proactive plan aims to prevent crises from occurring by identifying health and safety risks and strategies to *address them*.
- A reactive plan aims to avoid diminished quality of life when crises occur by having a plan in place to respond.
- Consider what the crisis may look like should it occur, to whom it will be considered a "crisis", and how to stay calm and to lend that strength to others in handling the situation capably.
- It will be important that you know what positive skills the person has which can be elicited and increased at times of crisis. Redirection of energies towards exercising these skills can prevent crisis escalation. Positive behavioral supports may be relied upon as a crisis response.
- The crisis plan is an active and living document that is to be used in the event of a crisis. After crisis, person and staff should meet to discuss how well the plan worked and make changes as indicated.

Health and behavioral concerns that may trigger the onset of a crisis (include lessons learned from previous crisis events):

- *Include information on health and wellness issues. Are there physical medical issues that contribute to this person's vulnerability to crisis? Are there physical medical issues that need to be addressed in the wake of a crisis?*
- *Describe in detail the known behaviors a person/family may identify which indicate to others that they need to take over responsibility for that person's care and make decisions on that person's behalf. Include information on the kinds of supports that may be effective for this person.*
- *Include information on environmental factors that may contribute to the onset of crisis and how those could possibly be controlled.*
- *Include information learned from previous episodes that may contribute to the success of crisis de-escalation or crisis diversion actions.*
- *Incorporate information gathered from all 3 Dialogue/Interview sections of the PCP.*

Crisis Prevention/Crisis Response – (Page 7 of PCP): Continued

Crisis prevention and early intervention strategies (List everything that can be done to help this person avoid a crisis):

- *List coping skills the person has learned or has used in the past to decrease the potential of going into crisis.*
- *Provide a detailed description of strategies that will be used to assist the person in avoiding a crisis. Strategies should be based on knowledge, information, and feedback from the person/family and other team members as well as strategies that have been effective in the past. Include opportunities for the person to exercise self-soothing skills developed and calming strategies such as consciously breathing deeply.*
- *Incorporate information gathered from the Personal Dialogue/Interview, from the Family/Guardian/Informal Supports Dialogues/Interviews and from the Service/Support Provider Dialogues/Interviews.*

Strategies for crisis response and stabilization (Focus first on natural and community supports. Begin with least restrictive steps. Include process for obtaining back-up in case of emergency and planning for use of respite, if an option. List everything you know that has worked to help this person to become stable):

- *Provide a detailed description of strategies to be implemented to help the person/family stabilize during a crisis. Strategies should be based on knowledge, information and feedback from the person/family and other team members as well as effective intervention strategies identified during the person's day to day life and from previous crises and problem resolution.*
- *Steps should focus first on natural and community supports, starting with the least restrictive interventions.*
- *Incorporate information gathered from the Personal Dialogue/Interview, the Family/Guardian/Informal Supports Dialogues/ Interviews and from the Service/Support Provider Dialogues/Interviews.*
- *Positive behavioral supports and approaches other than calling in law enforcement to deal with a crisis should be sought. Law enforcement should be called as a last resort only. If calling law enforcement is part of the plan, law enforcement should be involved in the plan development and their agreement obtained ahead of time.*

Specific recommendations for interacting with the person receiving a Crisis Service:

- *List specific detailed information learned from this person/family about the type of interaction and treatment that is helpful during a crisis and also the type of things that need to be avoided.*
- *Incorporate information gathered from the 3 Dialogue/Interview sections of the PCP.*
- *Remember, this information is for use at a Crisis Service, most likely by staff who does not know this individual/family well or at all. What do they need to know or do immediately?*

Strategies identified to be followed after a crisis to determine what worked and what did not work, and make changes to the PCP including this Crisis Plan:

- *Identify activities ahead of time which will be followed after a crisis, to determine what worked and what didn't work during the crisis episode.*
- *Include information as processed and accessed by the individual/family, members of the planning team, crisis response staff and any others involved in the crisis episode regarding effective and ineffective strategies.*
- *Include the process for update/revision of the Crisis Plan based on information learned.*

Crisis Prevention/Crisis Response – (Page 7 of PCP): Continued

CONSENTS/RELEASES OF INFORMATION (For Individuals or agencies included on the Contact List below).
The Individual or Legally Responsible Person has given legal, written consent for the following:

- ☐ The First Responder agency to release information to a Crisis Service provider.
- ☐ The Natural/Community Supports listed to be contacted during a crisis.
- ☐ The Professional Supports/treating Psychiatrist or Other Professional Supports listed to be contacted during a crisis.
- ☐ The Primary Care Physician listed to be contacted during a crisis.
- ☐ The preferred Psychiatric Inpatient provider or Respite provider to be contacted during a crisis.
- ☐ The Crisis Plan to be distributed to those on the Crisis Plan Distribution List.
- ☐ Other: _____

- The Consents/Releases of Information must be in place in each individual's service record before any information regarding a crisis, or distribution of the Crisis Plan can occur.
- Ensure that there are no individuals/agencies included on the Contact List for whom there is not consent/release of information in the record.

J. Crisis Prevention/Crisis Response (Continuation) – (Page 8 of PCP)

Contact List (Include names as applicable, relationship and direct phone numbers or extension.)

First Responder: Telephone #:

- ***Name****: Enter the name of the clinical home agency and if possible, the individual within the clinical home agency responsible for ensuring first response in case of emergency. For persons in residential services, that service provider is the first responder under crisis situations.*
- ***Telephone****: Enter the telephone number of the first responder/clinical home responsible for ensuring first response in case of emergency. Designate if after hours number.*

Legally Responsible Person: (NOTE: Complete if NOT the individual) Telephone #:
If applicable – Attach a copy of any applicable supporting legal documents, such as Court-Ordered Guardianship, Power of Attorney, etc.)
Date of Legal Document: (*mm/dd/yyyy)*

- *When applied to an adult who has been adjudicated incompetent, this is a guardian;*
- *When applied to a minor, a parent, guardian, a person standing in loco parentis (in the place of the parent when there is verified intent for this person to provide long-term care for the identified minor), or a legal custodian other than a parent who has been granted specific authority by law or in a custody order to consent for medical care, including psychiatric treatment;*
- *When applied to an adult who is incapable as defined in G.S. 122C-72(c) and who has not been adjudicated incompetent, a health care agent named pursuant to a valid health care power of attorney as prescribed in Article 3 of Chapter 32 of the General Statutes. [NC G.S.122C-3 (20)]*
- *Telephone: Enter the telephone number where the legally responsible person can be reached.*

Natural/Community Supports:
Name: Telephone #:

- ***Name:*** *Enter the name(s) of the individual(s) providing natural/community supports to be contacted during a crisis.*
- ***Telephone:*** *Enter the telephone number where the identified individuals providing natural/community supports can be reached.*

Crisis Prevention/Crisis Response (Continuation) – (Page 8 of PCP): Continued

Professional Supports:

Name: Telephone #:

- ***Name:*** *Enter the name of the psychiatrist or other professional providing care to the individual and designated to be contacted during a crisis.*
- ***Telephone:*** *Enter the telephone number for the identified professional.*

Primary Care Physician: Telephone #:

- ***Name:*** *Enter the name of the physician responsible for the overall medical care of the person.*
- ***Telephone:*** *Enter the telephone number for the identified primary care physician.*

Preferred Psychiatric Inpatient / Crisis Respite Provider: Telephone #:

- ***Name:*** *Enter the name of the preferred inpatient psychiatric facility or the crisis respite provider as identified by the team.*
- ***Telephone:*** *Enter the telephone number for the psychiatric inpatient or respite provider.*

Other Professional Supports:

Name: _____ Telephone #:

- ***Name:*** *Enter the name of the individual(s) providing other professional supports who are to be contacted during a crisis.*
- ***Telephone:*** *Enter the telephone number of the individual(s) providing professional supports.*

Advanced Directives: (Advance Directives allow you to plan ahead for care in the event that there are times that you are unable to speak for yourself).

I have a Living Will. ☐ Yes ☐ No If no, I would like one. ☐

I have a Health Care Power of Attorney. ☐ Yes ☐ No If no, I would like one. ☐

I have an Advanced Instruction for Mental Health Treatment. ☐ Yes ☐ No If no, I would like one. ☐

- ***Advance Directives:*** *Enter yes or no to the existence of a living will, health care power of attorney or advance directives for mental health treatment. If the person has any of these, attach a copy. If the person does not have them, explain the options.*
  1. ***Living Will*** *- All competent adults have the right to make decisions in advance about issues such as life support when it is clear that death is imminent or a state of coma becomes permanent. With a living will in place, the legally responsible party can make sure that the person's wishes are honored.*
  2. ***Health Care Power of Attorney*** *- Also known as a durable power of attorney for health care, this document can be helpful when the person is unable to make medical decisions for him/herself. It may also be referred to as a health care proxy or a medical power of attorney. It names someone who represents the person's wishes. Unlike the living will, which usually is limited to terminally ill patients, this document applies whenever the person is unable to make medical decisions.*

Crisis Prevention/Crisis Response (Continuation) – (Page 8 of PCP): Continued

3. ***Advance Instruction for Mental Health Treatment*** *- [NC General Statute122C-72 (1)] Advance instruction for mental health treatment or advance instruction means a written instrument signed in the presence of two qualified witnesses who believe the person to be of sound mind at the time of the signing, and acknowledge that before a notary public. In this document, the person gives instructions, information, and preferences regarding mental health treatment.*

Emergency Contact or Next of Kin: *(Enter the person's choice of a person to contact in an emergency)*
Relationship to Person: *(Enter how the emergency contact is related to the person)*
Address: *(Enter the street or mailing address of the emergency contact)*
City/State/Zip: *(Enter the city, state and zip code for the street or mailing address of the emergency contact)*
Home Phone: *(Enter the telephone number for the residence of the emergency contact)*
Work or Cell Phone: *(Enter an alternate telephone number where the emergency contact may be reached, if applicable)*

Crisis Plan Distribution List: (List contact information) *Enter the names of all individuals/agencies receiving copies of the crisis plan. There must be consent/release of information signed for each person listed.*

K. Signature Page – (Page 9 & 10 of PCP)

(Section I): SIGNATURES

For Medical Necessity of MEDICAID funded services:

- **A Licensed physician, licensed psychologist, licensed physician assistant or licensed family nurse practitioner** must sign the PCP in **Section A:**
  - Confirming the requested services are medically necessary.
  - Indicating whether the LP signing has had direct contact with the individual.
  - Indicating whether the LP signing has reviewed the Comprehensive Clinical Assessment.
- **If not ordered by an LP, a Qualified Professional (QP) must order CAP-MR/DD services and Medicaid funded Targeted Case Management (TCM) services, in Section B**. The signature confirms one or both of the following:
  - The requested CAP-MR/DD services are medically necessary.
  - The requested Medicaid-funded TCM services are medically necessary.
- In all cases, the signature and the date of the signature are REQUIRED.
- The signature is authenticated when the designated professional signing enters the date next to his/her signature.
- The signature serves as the Service Order for services contained in the Person-Centered Plan.
- Do not present the signature page to the LP to sign if not attached to a fully completed and dated PCP.
- A provider may not bill Medicaid for services until this signature is acquired.
- The annual review of medical necessity is due upon the annual rewrite of the PCP.
- ***(NOTE: Check boxes left blank on the signature pages of the PCP will be returned as incomplete by the Service Authorization Agency.)***
- ***(NOTE: DHHS shall report the failure of a licensed professional to comply with the above requirements to the licensed professional's occupational licensing board.)***

Signature Page – (Page 9 & 10 of PCP): Continued

(Section I): SIGNATURES

For Medical Necessity of STATE funded services:

- **The process above for Medical Necessity of Medicaid funded services is RECOMMENDED for verifying medical necessity and ordering of State funded services.**
- The process above will prevent the possibility of services being provided without a service order should the individual move from State funded services to Medicaid.
- If a licensed professional listed above does NOT confirm medical necessity, it is then RECOMMENDED that the **person responsible for the plan/clinical home QP** sign the person-centered plan **in Part I, Section B on the Signature page,** confirming that medical necessity criteria is met for the services included in the plan. **If not confirming medical necessity, the QP must still sign as the person responsible for the PCP in Part IV of the Signature page.**
- One of these signatures (in Part I, Section B; or Part IV) and the date of the signature are REQUIRED. The signature is authenticated when the designated professional signing enters the date next to his/her signature.
- A signature in Part I, Section B serves as the Service Order for state-funded services contained in the Person-Centered Plan.
- The signature is authenticated when the individual signing enters the date next to his/her signature.
- The annual review of medical necessity is due upon the annual rewrite of the PCP.

I. SERVICE ORDERS: ***REQUIRED for all Medicaid funded services; RECOMMENDED for State funded services.***

(SECTION A): For services ordered by one of the following Medicaid approved licensed signatories. (See Instruction Manual).

My signature below confirms the following: (Check all appropriate boxes.)

- Medical necessity for services requested is present, and constitutes the Service Order(s).
- The licensed professional who signs this service order has had direct contact with the individual - ☐ Yes ☐ No
- The licensed professional who signs this service order has reviewed the individual's assessment - ☐ Yes ☐ No

Signature: _____ License #: _____ Date: __/__/____

(Name/Title Required)

(SECTION B): For Qualified Professionals (QP)/Licensed Professionals (LP) ordering:

- CAP-MR/DD or
- Medicaid Targeted Case Management (TCM) services (if not ordered in Section A)
- **OR recommended** for any state-funded services not ordered in Section A.

My signature below confirms the following: (Check all appropriate boxes.)

☐ Medical necessity for the CAP-MR/DD services requested is present, and constitutes the Service Order.
☐ Medical necessity for the Medicaid TCM service requested is present, and constitutes the Service Order.
☐ Medical necessity for the State-funded service(s) requested is present, and constitutes the Service Order.

Signature: _____ License # _____ Date: __/__/____

(Name/Title Required. Signatory in this section must be a Qualified/Licensed Professional.) (If Applicable)

Annual review of medical necessity and re-ordering of services is due upon the annual rewrite of the Person Centered Plan (PCP)

Signature Page – (Page 9 & 10 of PCP): Continued

(Section II.): Signature of Person Receiving Services

- The person receiving services is required to sign and date the PCP in Part II indicating confirmation and agreement with the services and supports detailed and confirmation of choice of service provider(s) *if the individual is his/her own legally responsible person*.
- The signature is authenticated when the individual signing enters the date next to his/her signature.
- Do not present the Signature Page to the individual to sign if not attached to a fully completed and dated PCP.
- A provider may not bill Medicaid for services until this signature is acquired if the individual is his/her own legally responsible person.
- All individuals are highly encouraged to sign their own PCPs.

(MINORS)

- A minor may and/or must sign the plan under the following conditions: If the minor is receiving mental health services as allowed in NC General Statute 90-21, the minor's signature on the plan is sufficient. However, once the legally responsible person becomes involved, the legally responsible person shall also sign the plan.
- For **minors receiving outpatient substance abuse services**, the plan shall include both the staff and the child or adolescent's signatures demonstrating the involvement of all parties in the development of the plan and the child or adolescent's consent/agreement to the plan. Consistent with North Carolina law (NC General Statute 90-21.5), the plan may be implemented without parental consent when services are provided under the direction and supervision of a physician. When services are not provided under the direction and supervision of a physician, the plan shall also require the signature of the parent or guardian of the child or adolescent demonstrating the involvement of the parent or guardian in the development of the plan and the parent's or guardian's consent/agreement to the plan.
- For an **emergency admission to a 24-hour facility, per NC General Statute 122C- 223(a)**, "in an emergency situation when the legally responsible person does not appear with the minor to apply for admission, a minor who is mentally ill or a substance abuser and in need of treatment may be admitted to a 24-hour facility upon his own application." In this case, the minor's signature on the plan would be sufficient.
- For an **emergency admission to a 24-hour facility, per NC General Statute 122C-223(b)**, "within 24 hours of admission, the facility shall notify the legally responsible person of the admission unless notification is impossible due to an inability to identify, to locate, or to contact him after all reasonable means to establish contact have been attempted." Once contacted, the legally responsible person is required to sign the plan.
- For an **emergency admission to a 24-hour facility, per NC General Statute 122C-223(c)**, "If the legally responsible person cannot be located within 72 hours of admission, the responsible professional shall initiate proceedings for juvenile protective services." In this case, the individual designated from juvenile protective services shall sign the plan.

***NOTE**: For minors receiving substance abuse services in a non-emergency admission to a 24-hour facility, both the legally responsible person and the minor are required to sign the plan.*

***NOTE:** Within Substance Abuse Non-Medical Community Residential Treatment, Residential Recovery Programs for women and children the Person-Centered Plan shall also include goals for the parent-child interaction.*

Signature Page – (Page 9 & 10 of PCP): Continued

II. PERSON RECEIVING SERVICES

- I confirm and agree with my involvement in the development of this PCP. My signature means that I agree with the services/supports to be provided.
- I understand that I have the choice of service providers and may change service providers at any time, by contacting the person responsible for my plan.

Signature: _____ Date: __/__/____

(Required when person is his/her own legally responsible person)

(Section III.): LEGALLY RESPONSIBLE PERSON

- **The legally responsible person, if not the person to whom the PCP belongs, signs and dates the PCP in Part III confirming:**
  - ❖ Involvement in the development of the PCP, and agreement with the services to be provided.
  - ❖ Understanding that he/she has the choice of service providers, and may change providers at any time.
  - ❖ For CAP-MR/DD services only, understanding that he/she has the choice of seeking care in an ICF-MR facility in lieu of CAP-MR/DD services.
- This signature and the date of the signature is REQUIRED.
- <u>The signature is authenticated when the individual signing enters the date next to his/her signature.</u>
- Do not present the Signature Page to the Legally Responsible Person to sign if not attached to a fully completed and dated PCP.
- A provider may not bill Medicaid for services until this signature is acquired.

III. LEGALLY RESPONSIBLE PERSON: *Required if other than the person to whom the PCP belongs.*

- I confirm and agree with my involvement in the development of this PCP. My signature means that I agree with the services/supports to be provided.
- I understand that I have the choice of service providers and may change service providers at any time, by contacting the person responsible for this PCP.
- For CAP-MR/DD services, I confirm and understand that I have the choice of seeking care in an intermediate care facility for individuals with mental retardation instead of participating in the Community Alternatives Program for individuals with mental retardation/developmental disabilities (CAP-MR/DD).

Signature: _____ Date: __/__/____

(Required, if other than the individual)

Signature Page – (Page 9 & 10 of PCP): Continued

(Section IV): PERSON RESPONSIBLE FOR THE PCP

- The QP/LP representing the person's clinical home and responsible for the PCP development signs and dates the plan confirming involvement and agreement with the services and supports detailed in the PCP.
- This signature and the date of the signature is REQUIRED.
- The date of the QP/LP signatures should coincide with the Date of Plan.
- The signature is authenticated when the individual signing enters the date next to his/her signature.
- **For Adults (21 years of age for Medicaid, 18 years of age for State funded services),** the person responsible for the PCP signs and dates the plan in Part IV of the Signature page, directly under the statement, "For Adults…"
- **For Children/Adolescents (less than 21 years of age for Medicaid, less than 18 for State funded services),** who are receiving or in need of enhanced services and who are actively involved with the Department of Juvenile Justice and Delinquency Prevention or the adult criminal court system, the **signature of the person responsible for the PCP in Part IV of the Signature page attests that he/she has completed the following requirements:**
  - ❖ Met with the Child and Family Team, OR
  - ❖ Scheduled a Child and Family Team meeting, OR
  - ❖ Assigned a TASC Care Manager, AND
  - ❖ Conferred with the clinical staff of the applicable LME to conduct care coordination.

IV. PERSON RESPONSIBLE FOR THE PCP: The following signature confirms the responsibility of the QP/LP for the development of this PCP. The signature indicates agreement with the services/supports to be provided.
***For Adults (21 years of age for Medicaid, 18 years of age for State funded services)**

Signature: _____ Date: / /
(Person Responsible for the PCP)

For individuals who are less than 21 years of age for Medicaid (less than 18 for State funded services) and who are receiving or in need of enhanced services and who are actively involved with the Department of Juvenile Justice and Delinquency Prevention or the adult criminal court system, the person responsible for the PCP must attest that he or she has completed the following requirements as specified below:

☐ Met with the Child and Family Team - Date: / /
☐ **OR** Child and Family Team meeting scheduled for - Date: / /
☐ **OR** Assigned a TASC Care Manager - Date: / /
☐ **AND** conferred with the clinical staff of the applicable LME to conduct care coordination.

If the statements above do not apply, please check the box below and then sign as the Person Responsible for the PCP:
☐ This child is not actively involved with the Department of Juvenile Justice and Prevention or the adult criminal court system.

Signature: _____ Date: / /
(Person Responsible for the PCP)

Signature Page – (Page 9 & 10 of PCP): Continued

(Section V.): OTHER TEAM MEMBERS:

- Other team members have the option to sign and date the PCP confirming participation and agreement with the services and supports detailed in the PCP.

V. OTHER TEAM MEMBERS

Other Team Member Signature: _____ Date: / /
Other Team Member Signature: _____ Date: / /
Other Team Member Signature: _____ Date: / /

V. SUPPLEMENTAL PCP PAGES

The following are supplemental pages to be used as needed or recommended during the plan year.

- PCPs must be reviewed if the person's needs change, if there is a change in provider and/or based on assigned target dates.
- If any review results in a new service being added or a new goal(s) being added, or anything that cannot be explained in the "Justification" space next to the Status Code, use the PCP Update/Revision page.
- Any time the Update/Revision page is used, the Update/Revision Signature page must also be completed.

A. PCP Update/Revision – (Supplemental Page 1 of PCP)

Identifying Information

Name: *(Person's legal name)* **Preferred Name:** *(Enter the name that the person prefers to be called)*	**DOB:** (*mm/dd/yyyy)*	**Medicaid ID:** (*Enter identification noted on current Medicaid card)*	**Record #:** (*Enter the record number assigned by the LME)*
Person's Address: **(Street/mailing address)** **(City/State/Zip)**			**Telephone #:** (*Enter the telephone number of the person receiving services)*
Update/Revision Date: (*mm/dd/yyyy)*			

PCP Update/Revision – (Supplemental Page 1 of PCP): Continued

Long Range Outcome:

In measurable terms, state the person-centered outcome the individual desires to achieve within a year or into his/her future.

Where am I now in the process of achieving this outcome?

Briefly describe the person's current status, skills and abilities related to the identified long range outcome and the person's current level of participation related to this outcome.

CHARACTERISTICS/OBSERVATION #: *(List the characteristics/observation from the Summary of Assessments/Observations page here that supports the need for the short range goal below. Use clinical judgment to recognize the relationship between the characteristics/observations and the short term goals. More than one goal may be developed for a single characteristics/observation if necessary to fully address that need.*

Short Range Goal (Taken from Preferences & Supports Sections ("What's important TO & FOR me")	**Support/Intervention to Reach Goal (Taken from Supports Sections)**	**Who will Provide Support/Intervention/ Service?**	**Support/Service**
Enter a person-centered measurable objective needed to achieve the long range outcome based on the Preferences and Supports sections of the interviews and including the "What's important to and for me" information.	*Define the supports/interventions/services required to achieve the short range goal based on the Supports sections of the interviews.*	*Identify the individual(s) who will be responsible for implementing and documenting the progress toward the goal. When the responsible person is a paid provider, indicate the agency name and the position of the person in this box. When possible, include the name of that individual as well.*	*Identify the specific service/treatment to be used to address the goal and enter the frequency of the service.*

Target Date (Not to exceed 12 months.)	**Reviewed Date**	**Status Code**	**Justification for Continuation/Discontinuation of Goal**
Enter the date the team projects the person can achieve this goal. A target date may never exceed 12 months from the Date of Plan.	*Enter the date progress towards the goal was reviewed.*	*Based on the progress review, enter the status code.*	*If a goal is not achieved at the time of review, provide information justifying the reason the team determines to either continue or discontinue the goal.*
/ /	/ /	*(Enter the Status Code)*	*(Enter the Justification of Continuation/Discontinuation of Goal)*

Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued

B. PCP Update/Revision Signatures – (Supplemental Pages 2 & 3 of PCP)

1. **<u>For Medicaid funded services</u>:**
   - **When the Update/Revision includes a *new service(s)***, a licensed physician, licensed psychologist, licensed physician assistant or licensed family nurse practitioner must sign and date the Update/Revision indicating that requested service(s) are medically necessary, indicating whether the LP had face to face contact with the individual and whether the LP reviewed the Assessments. **The dated signature serves as the Service Order(s).**
   - This signature and the date of the signature are REQUIRED. <u>The signature is authenticated when the individual signing enters the date next to his/her signature.</u>
   - Do not present the Update/Revision Signature Page to the LP to sign if not attached to a fully completed and dated Update/Revision.

2. **<u>For State funded services</u>:**
   - **When the Update/Revision includes a *new service(s),*** it is RECOMMENDED that a licensed physician, licensed psychologist, licensed physician's assistant or licensed family nurse practitioner sign the Update/Revision indicating that the services contained in the plan are medically necessary. This signature serves as a Service Order and will prevent the possibility of services being provided without a service order should the individual move from State-funded services to Medicaid.
   - If the recommended signatures above are not obtained, it is then RECOMMENDED that the **person responsible for the plan/clinical home** sign the Update/Revision indicating the medical necessity has been met and ordering the service(s). *(Note: The person responsible for the plan/clinical home must sign the update/revision even if the service(s) is ordered per the Medicaid requirement above. In this case, the signature confirms involvement and agreement with the services and supports detailed in the update/revision, but does not constitute the service order.)*

C. Learning Log – (Supplemental Page 4 of PCP)

- Anytime there is a serious event or when a situation needs to be considered more closely, it is recommended that providers complete the **Learning Log** to understand how to better support the individual. Additionally, it is recommended that the Learning Log accompany the PCP Update/Revision pages.

"LEARNING LOG"

How this tool helps

- Provides a way for people to record ongoing learning (focused on what worked well, what didn't work well) for any event or activity.
- Tells us what is important to and for individuals, families and team plans.
- Helps us to focus more clearly on critical information about the person.
- Can be used to focus on someone's whole life or specific areas of their life, e.g. someone's health, how people like to spend their time.

What it does

- Directs people to look for ongoing learning.
- Provides a structure that captures details of learning within specific activities and experiences.
- Provides a way of recording information which focuses on what needs to stay the same and what needs to change for the individual being supported.

Smull and Sanderson, 2007

LEARNING LOG

Date	What did the person do? (What, where, when, how long, etc.)	Who was there? (Names of staff, friends, others, etc.)	What did you learn about what worked well? What did the person like about the activity? What needs to stay the same?	What did you learn about what didn't work well? What did the person not like about the activity? What needs to be different?

D. Did We Get it Right? – (Supplemental Page 5 of PCP)

- In supporting evidence based practice on seeing the PCP as a "description" of someone's life, the following 3 questions are designed as prompts to ensure commitment to the person-centered planning process.

Did We Get it Right?

/ /

- **Does this plan describe who you are? (Explain)**

- **Does this plan describe what you want to do in your life? (Explain)**

- **Does this plan describe the support you need to do these things? (Explain)**

VI. APPENDIX

A. Excerpt from NC Division of MH/DD/SAS Implementation Update #36

November 5, 2007

(MEMORANDUM)

SUBJECT: Implementation Update #36: Changes to Implementation Updates, Community Support Service, Comprehensive Clinical Assessment, Training and CAP-MR/DD Endorsement

Comprehensive Clinical Assessment

We have received numerous questions about the function and requirements for a comprehensive clinical assessment in person centered planning. A "comprehensive clinical assessment" is not a service definition; rather it is an intensive clinical and functional face-to-face evaluation of an individual's presenting mental health, developmental disability, and/or substance abuse condition that results in the issuance of a written report, providing the clinical basis for the development of the Introductory Person Centered Plan (PCP), the Complete PCP, or the service plan when a PCP is not required. This written report also includes recommendations for services, supports, and/or treatment. Through a comprehensive clinical assessment, the information essential to formulating a diagnosis and plan of treatment is gathered. A comprehensive assessment can be billed through a variety of evaluation and assessment procedure codes including, but not limited to:

- Diagnostic Assessment (performed according to the service definition): T1023
- Evaluation/Intake: 90801, 90802
- Assessment: H0001, H0031
- Evaluation & Management (E/M) Codes
- State Substance Abuse Assessment: YP830 (not Medicaid billable)

The elements listed below for a comprehensive clinical assessment are accepted by our Divisions as meeting the standards for an initial professional assessment. The purpose of the comprehensive clinical assessment is to provide the Qualified Professional with the necessary data and recommendations to perform the analysis and synthesis of this information in the development of the PCP with the consumer. A comprehensive clinical assessment offers an opinion as to whether the consumer is appropriate for and can benefit from mental health, developmental disabilities, and/or substance abuse services. It also evaluates the consumer's level of readiness and motivation to engage in treatment and, for individuals with substance abuse conditions, recommends a level of placement using the American Society of Addiction Medicine (ASAM) Criteria. For individuals with developmental disabilities it provides a basis for identifying the comprehensive service and support needs of the consumer. For some individuals being evaluated for membership in a target population (applicable to state-funded consumers only), certain diagnostic tools specified by DMH/DD/SAS must also be utilized and become a part of the data used to develop the PCP. For example, the SUDDS-IV, ASI, or SASSI-3 are required for specific substance abuse target populations, or intellectual and adaptive functioning assessments are required for persons with developmental disabilities. In these cases, the Qualified Professional completing the PCP may be analyzing the report from the professional who performed the comprehensive clinical assessment as well as the report from the psychologist who completed the psychological testing. The Service Records Manual (http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/aps/apsm_serv-record-manual-10-07.pdf)

provides a detailed discussion of service-specific assessment tools. For such specialized tests to be considered a comprehensive clinical assessment, the report must contain all the elements listed below.

An assessment completed at a State Operated Facility can fulfill the requirements of a comprehensive clinical assessment if it contains all of the required elements. If there have been changes in the clinical presentation of the consumer since the completion of the State Operated Facility's assessment, an additional assessment may be needed.

The format of a comprehensive clinical assessment is determined by the individual provider based on the clinical presentation. Although a comprehensive clinical assessment does not have a designated format, the assessment (or collective assessments) used must include the following elements:

A. A chronological general health and behavioral health history (including mental health and substance abuse) of the consumer's symptoms, treatment, treatment response and attitudes about treatment over time, emphasizing factors that have contributed to or inhibited previous recovery efforts;

B. Biological, psychological, familial, social, developmental and environmental dimensions which identifies strengths, weaknesses, risks, and protective factors in each area;

C. A description of the presenting problems, including source of distress, precipitating events, associated problems or symptoms, recent progressions, and current medications;

D. A strengths/protective factors/problem summary which addresses risk of harm, functional status, co-morbidity, recovery environment (MH/SA), and treatment and recovery history (MH/SA);

E. A strengths-based assessment that identifies the consumer/family functional strengths including natural and informal supports, preferences, needs, and cultural diversity issues;

F. Evidence of consumer/legally responsible person's participation in the assessment;

G. Recommendation regarding target population eligibility (state-funded services only);

H. An analysis and interpretation of the assessment information with an appropriate case formulation;

I. Diagnoses on all five (5) axes of DSM-IV; and

J. Recommendations for additional assessments, services, support, or treatment based on the results of the comprehensive clinical assessment.

Appendix A. gives further detail about how a comprehensive clinical assessment may be tailored to best meet the needs of the population served.

(Appendix A of Implementation Update #36)

Comprehensive Clinical Assessment by Population

The guidance below is specific to the consumer population being served.

Services for Children

In the case of children/youth and their families, the comprehensive clinical assessment should:

- address the prior existence and work of the Child and Family Team (CFT).
- if the family is new to services, recommend members of the Child and Family Team that the family and Qualified Professional will convene.
- assess the strengths of the child/youth and their family. Consider utilizing a strength-based assessment tool. For more information on Strength-Based Assessments go to: http://www.ncdhhs.gov/mhddsas/childandfamily/index-new.htm
- utilize information such as reports from psychological testing and/or Individualized Education Plans.

Recommendations for services from the comprehensive clinical assessment are considered by the CFT for person-centered planning. The assessment of strengths provides necessary information from which the Child and Family Team can begin their work.

Adult Mental Health

For all adults with a diagnosis of a major mental illness, the assessment should identify the clinical services appropriate to treat the diagnosed condition. The assessment should incorporate principles of education, wellness and recovery, empowerment in developing an inter-dependent partnership with the consumer during the diagnostic process. The assessment should also identify whether there is a need for additional evaluations such as psychological testing, psychiatric evaluation, medication evaluation, or additional assessments to identify potential co-occurring diagnoses. Upon the completion of the comprehensive clinical assessment process, the clinical practitioner(s) should work directly with the clinical home provider in the development of the PCP for services, natural supports, and crisis prevention activities all related to wellness management.

Developmental Disabilities Services

A comprehensive clinical assessment supports the person centered planning process for individuals with developmental disabilities. In many cases, persons with a developmental disability have multiple disabilities and present with complex profiles that necessitate a more comprehensive approach to addressing their needs. Since developmental disabilities are life long conditions, the focus of the comprehensive clinical assessment is on identifying the person's current functioning status and identifying needed supports to help the person achieve and maintain maximum independence. Such an approach often requires a variety of clinical assessments (e.g., intellectual assessment, psychiatric assessment, physical evaluation, educational/vocational assessment, PT/OT evaluation). It should also be noted that the assessment is not a one-time event. A person with a developmental disability may require periodic assessments to determine their ongoing needs.

Substance Abuse Services

The information gathered in the comprehensive clinical assessment should be utilized to determine the appropriate level of care using the ASAM Patient Placement -2 as a clinical guide. The ASAM level of care recommendation should be included in the disposition of the comprehensive clinical assessment.